

NEW PATIENT HISTORY QUESTIONNAIRE

Please answer the following questions to the best of your ability, and bring the completed form with you to your first visit. This form must be completed prior to your first visit. If you forget the form, we will gladly give you another copy to complete when you arrive.

Name: _____ SS #: _____

Chief Complaint - Reason for the visit : _____

PATIENT MEDICAL HISTORY

Check any of the conditions you have experienced in the past. Please state the date occurred, if known.

- | | |
|---|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Lung Disease _____ |
| <input type="checkbox"/> Heart Rhythm Problem _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Urinary Infections _____ |
| <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Ulcers _____ |
| <input type="checkbox"/> Blood Disorder _____ | <input type="checkbox"/> Blood Clots _____ |
| <input type="checkbox"/> Thyroid Disease _____ | <input type="checkbox"/> Substance Abuse _____ |
| <input type="checkbox"/> Circulatory Problems _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Emotional Problems _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Enlarged Lymph Nodes _____ | <input type="checkbox"/> Bruise Easily _____ |
| <input type="checkbox"/> Bleed Easily _____ | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> None _____ |

I have _____ been hospitalized.
_____ NEVER been hospitalized.

Please indicate the reason(s), date(s) and location(s) where you were hospitalized.

I have _____ had a blood transfusion.
_____ NEVER had a blood transfusion.

Please indicate the reason(s), date(s) and location(s) where you had the transfusion.

I have _____ had surgery.
_____ NEVER had surgery.

Please indicate the reason(s), date(s) and location(s) where the surgery was performed.

FAMILY HISTORY

All family history questions apply only to your biological family. Anyone to whom you are related through adoption or marriage (i.e. step-family) does not apply.

Biological Mother:

My mother is: _____ living _____ deceased _____ unknown

If deceased, please indicate the cause of death and age: _____

List your mother's medical problems: _____

Biological Father:

My father is: _____ living _____ deceased _____ unknown

If deceased, please indicate the cause of death and age: _____

List your father's medical problems: _____

Biological Brother(s):

Number of brothers living: _____ and deceased: _____

If deceased, please indicate the cause of death and age: _____

List your brother's medical problems: _____

Biological Sister(s):

Number of sisters living: _____ and deceased: _____

If deceased, please indicate the cause of death and age: _____

List your sister's medical problems: _____

Biological Children:

Number of children living: _____ and deceased: _____

If deceased, please indicate the cause of death and age: _____

List your children's medical problems: _____

FAMILY MEDICAL PROBLEMS

Please indicate if any of your biological family has any of the following problems:

- Heart Disease _____
- High Blood Pressure _____
- Stroke _____
- Kidney Disease _____
- Blood Disorder _____
- Cancer (type, if known) _____
- Thyroid Disease _____
- Diabetes _____
- Cholesterol Problems _____
- Emotional Problems _____
- Alcohol/Substance Abuse _____
- Other _____

SOCIAL HISTORY

- _____ I currently smoke.
- _____ I have never smoked.
- _____ I do not currently smoke but have in the past.
- _____ How many years have you smoked?
- _____ How many packs a day?
- _____ At what age did you start?
- _____ At what age did you stop?
- _____ I currently drink alcohol.
- _____ I have never drunk alcohol.
- _____ I do not currently drink alcohol but have in the past.
- _____ Approximate number of drinks per week

PATIENT'S CURRENT MEDICAL CONDITION

Please answer the following questions as they apply to you at the current time.

General

Yes No

- Weight gain?
 Weight loss?
 Night sweats?
 Fever or chills?
 Fatigue?

If yes, please explain: _____

Skin

Yes No

- Rash or redness?
 Itching?

If yes or other skin problems, please explain: _____

Eyes/Ears/Nose/Throat

Yes No

- Visual problems?
 Hearing problems?
 Trouble swallowing?
 Nosebleeds?
 Earache or drainage?

If yes or other related problem, please explain: _____

Heart/Lungs

Yes No

____ ____

Cough?

____ ____

Chest pain?

____ ____

Coughing blood?

____ ____

Shortness of breath?

____ ____

Palpitations?

____ ____

Increased shortness of breath with exertion?

If yes or other related problems, please explain: _____

Digestive/Dietary

Yes No

____ ____

Nausea or vomiting?

____ ____

Abdominal pain?

____ ____

Diarrhea?

____ ____

Constipation?

____ ____

Rectal pain or bleeding?

____ ____

Special diet?

If yes or other related problems, please explain: _____

Urinary Problems

Yes No

____ ____

Frequent urination?

____ ____

Painful urination?

____ ____

Blood in urine?

____ ____

Lack of control?

If yes or other related problems, please explain: _____

Genital/Reproductive Problems

Yes No

- Currently pregnant?
- Vaginal bleeding?
- Menstrual changes?
- Changes in sexual function?
- Hot flashes?

If yes or other related problems, please explain: _____

Age at first pregnancy? _____ Number of pregnancies? _____

Muscular/Skeletal Problems

Yes No

- Joint pain or swelling?
- Muscle pain or weakness?
- Jerking or twitching?
- Bone pain?
- Difficulty walking?

If yes or other related problems, please explain: _____

Neurological/Emotional Problems

Yes No

- Headaches?
- Dizziness?
- Seizures?
- Depression?
- Numbness?
- Fainting spells?
- Confusion?

If yes or other related problems, please explain: _____
